Health Care Quality and Cost
Governor's GMAP Forum

September 15, 2005

Health Care Authority (HCA)

Department of Social and Health Services (DSHS)

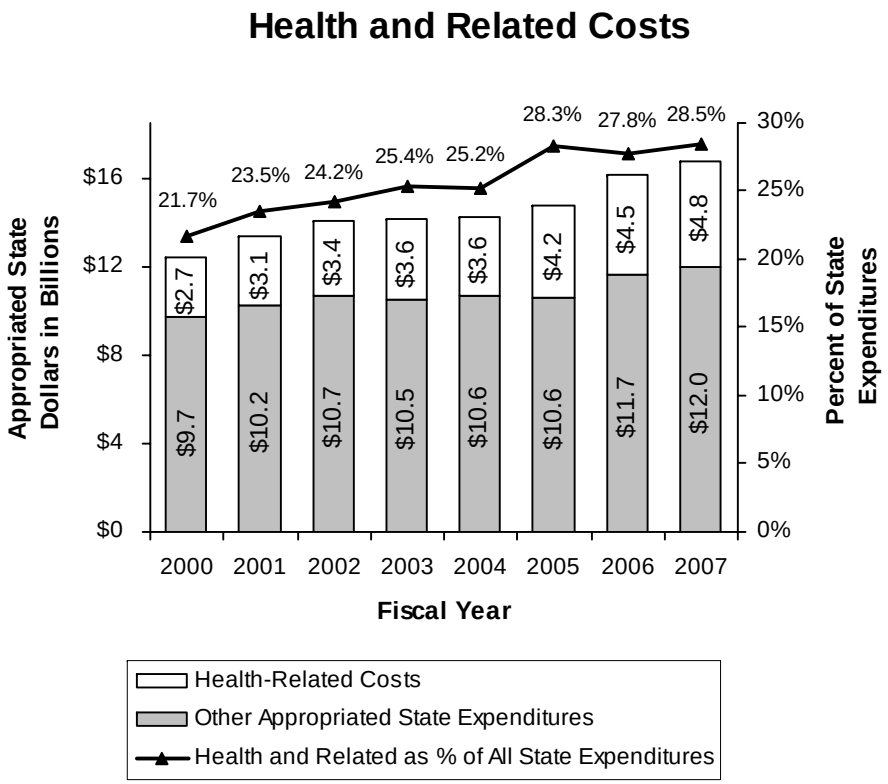
Department of Health (DOH)

Agenda

- This report is focused primarily on the Governor's priorities to improve health care by improving quality, reducing health care costs, covering all kids and increasing prevention strategies.
  - Prevention-Healthy Washington – Mary Selecky (DOH)
  - Cover All Kids – Robin Arnold-Williams (DSHS)
  - Quality & Cost Group – Steve Hill (HCA)

Health Care Authority/DSHS/Department of Health

What is the impact of Health Care Spending on State Resources?



Analysis

- Health and related costs are consuming larger portion of State resources each year. These are dollars not available for education, wages, and other social benefits.
- The growth trend in percent of State expenditures represents a $1.2 billion increase when comparing 2000 and 2007.

Action

- Reduce growth in health-related cost trend to compare with rate of State revenue growth.

Data notes: Source: State of Washington Office of Financial Management (July 2005). Health and related costs include Medicaid, Basic Health, public health; plus long-term, institutional, and behavioral health costs.

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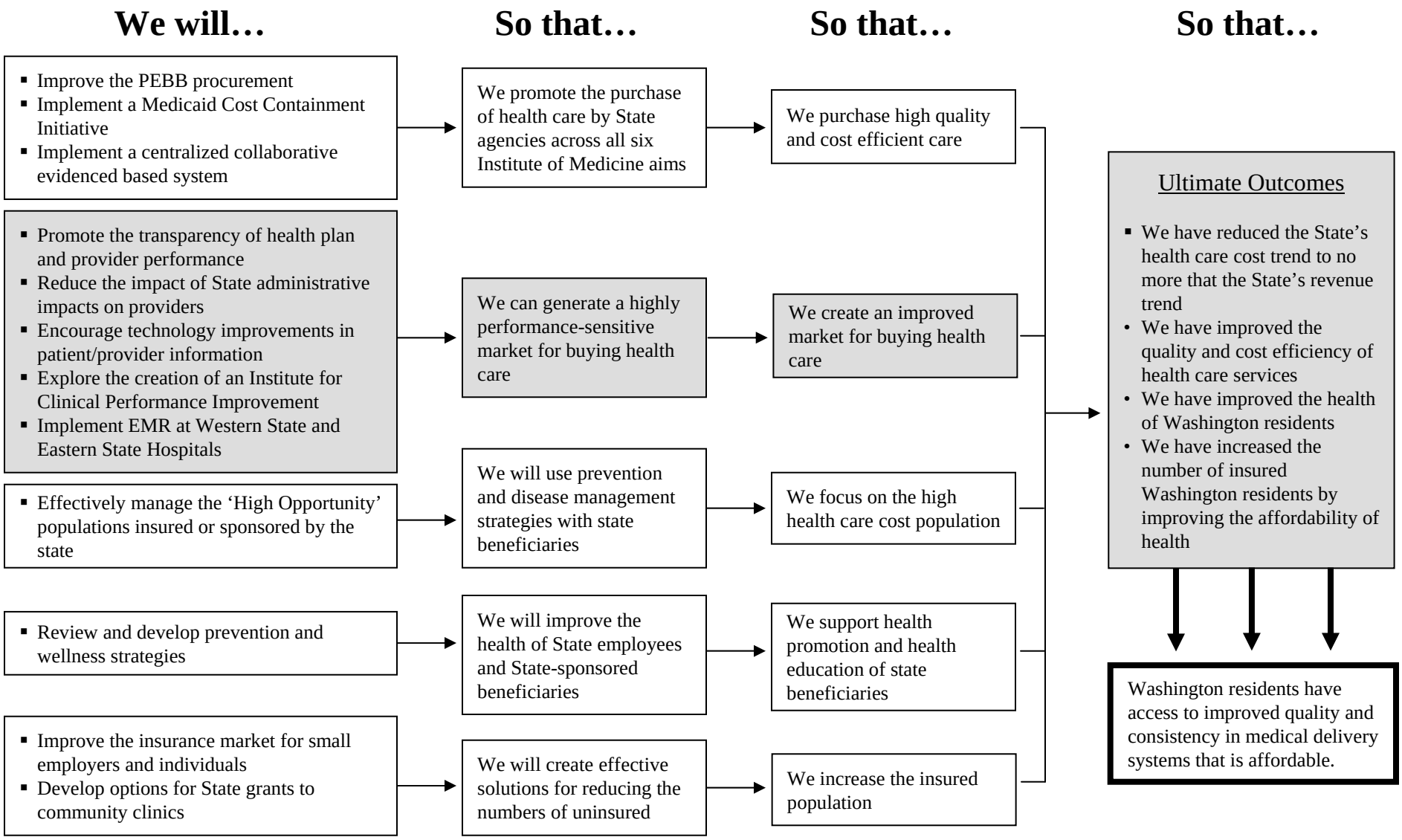
Health Care Quality and Cost Logic Model



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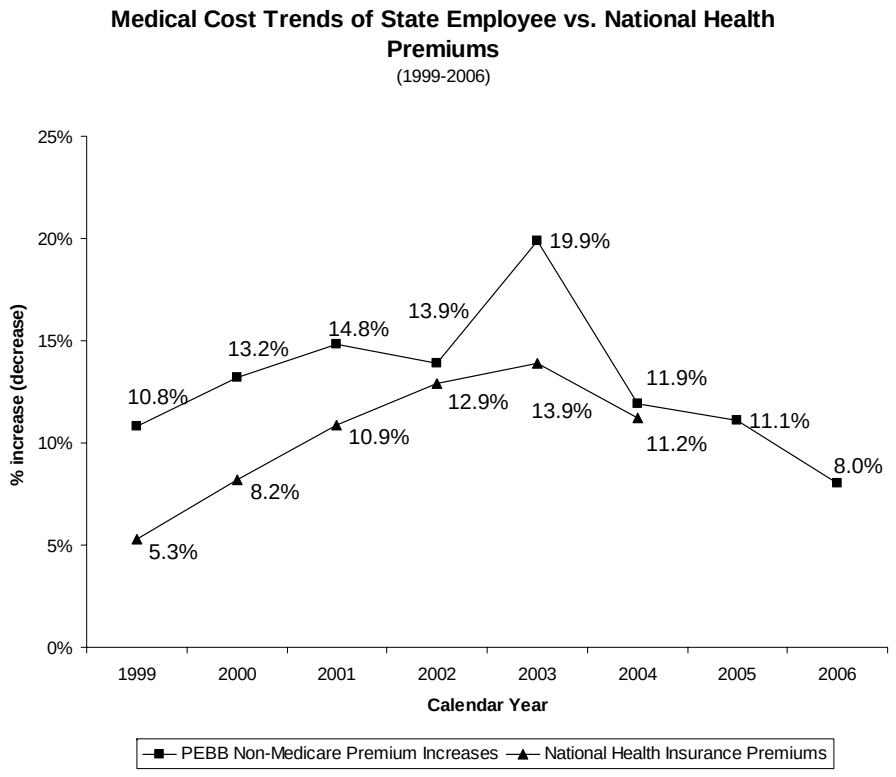
Goal 1: Reduce Cost Trend

How can we bring PEBB/K-12 health benefits in line with national trends?



Analysis

- Premium Increases = Bid Rate Increases for Public Employee Benefits.
- Fiscal Growth projected to be 3.8% 2005-09.
- Without material changes in delivery, bid rate trends will continue to increase by double digits.

Action

- Target: Get state cost trend below national trends.
- Improve Public Employee Benefits procurement to increase quality and lower cost:
  - Mix of plans (add another PPO)
  - Plan design strategies
  - Care management
  - Eligibility changes
- Promote transparency of plan performance across the six Institute of Medicine aims through State purchasing.
- Intensify administrative simplification efforts.

Data notes: PEBB Non-Medicare Premiums: Uniform Medical Plan (UMP) claims and Managed Care Organization (MCO) premiums. National Health Insurance Premiums: Kaiser/HRET Survey of Employer-Sponsored Health Benefits 2004.

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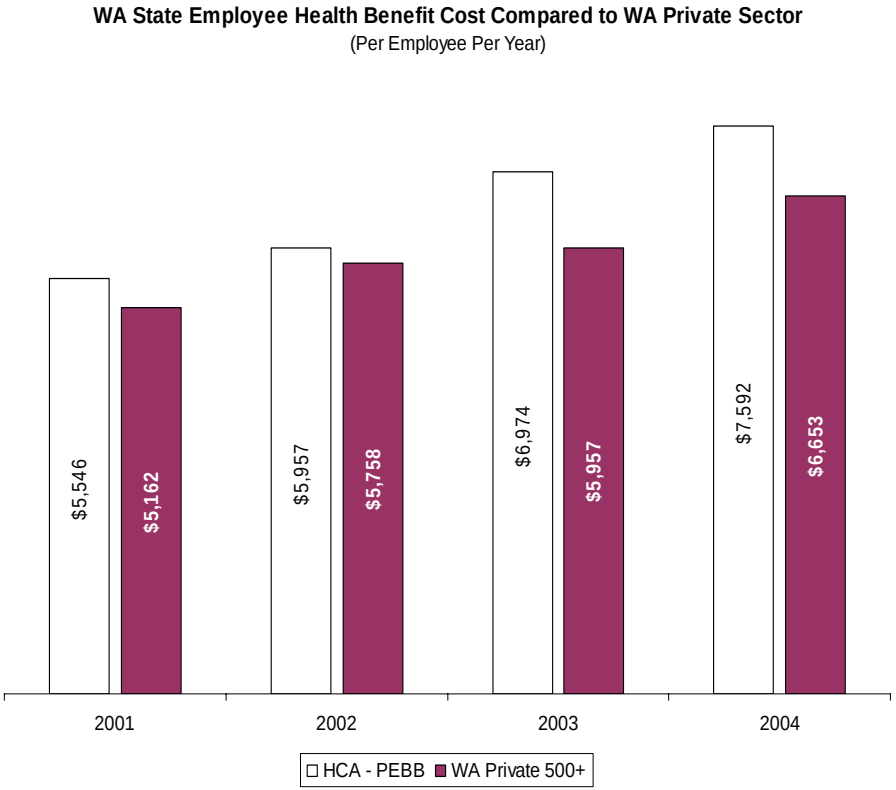
Is WA State paying more than large WA private sector employers?



Analysis

- WA State is spending more per employee for health benefits than large (500+) private sector employers in WA.

Action

- Improve the PEBB procurement strategy by:
  - Review Mix of plans
  - Plan design
  - Care Management
  - Eligibility
  - Data Warehouse
  - Benchmarking.
- Make sure state employee health care benefits are comparable and benchmark favorably to plans offered by other large employers in the State.

Data notes: Sources: 2002 & 2004 Mercer National Survey of Employer-Sponsored Health Plans. HCA Finance & Budget. Costs include medical, dental, Rx, and specialty benefits.

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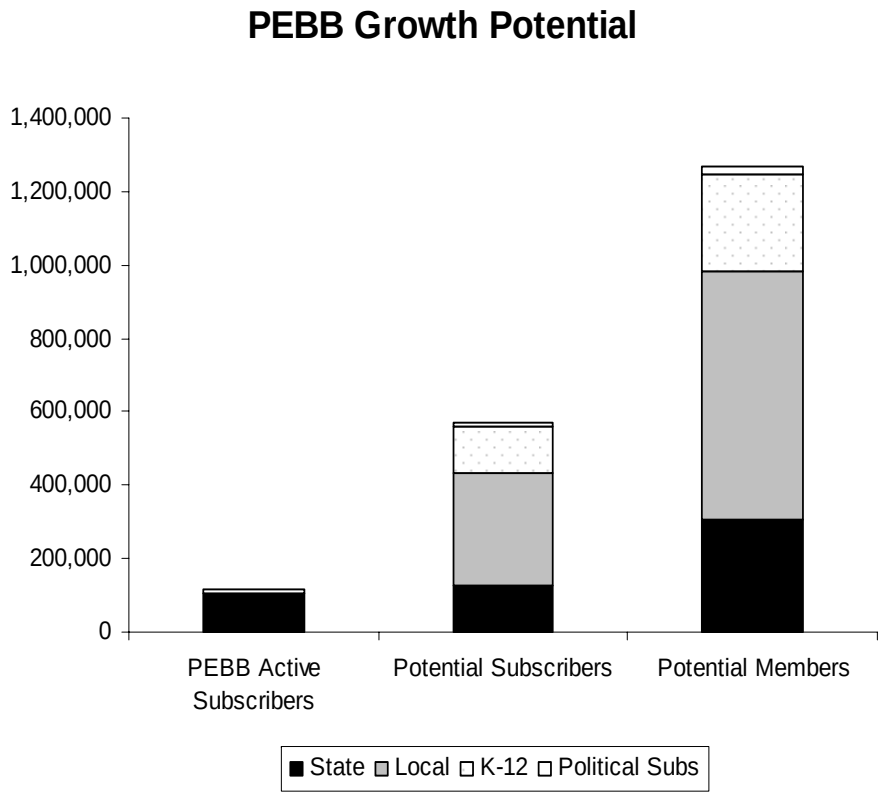
Goal 1: Reduce Cost Trend

What is the growth potential for PEBB?



Analysis

- Local governments and K-12 districts would strengthen PEBB collective purchasing power.

Action

- Structure benefits that attract these groups into a collaborative purchasing arrangement.

Data notes: Sources: Employment Security, Health Care Authority, and Office of Superintendents of Public Instruction. Data is from Q4 2004. Potential members for Local Gov is derived by multiplying employees by a factor of 2.2. Potential members for K-12 is derived by multiplying employees by a factor of 2.2, minus the current number of PEBB members.

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DSHS – 2005-07 Biennial Medical Care Savings Initiatives

What is DSHS doing to contain costs mandated by Legislature?

Medicaid 2005-07 Biennium Cost-Containment Initiatives	
Savings Initiatives	**Biennial Savings Target**
Expand State's Preferred Drug List	($6.9 million)
Expand Medicaid patients requiring restriction (PRR) program to reduce inappropriate use of medical services	(10.7 million)
Implement new Medicaid nutrition program protocols and rates to reduce inappropriate use of medical nutrition	($5.2 million)
Implement new Medicaid durable medical equipment (DME) purchasing strategies for incontinence supplies, wheel chairs, and other equipment	($8.2 million)
Improve collection efforts and increase audit and review activities to ensure appropriate expenditure by providers	($14.2 million)
Total	**($45.2 million)**

Analysis

- May not be able to implement the number of expanded preferred drug classes to achieve savings assumed in the budget.

Action

- Develop metrics to measure savings associated with each initiative.
- Assess if savings can be achieved through other drug utilization strategies and may request supplement budget for shortfall.

Data notes: 2005-07 appropriations act (ESSB6090)

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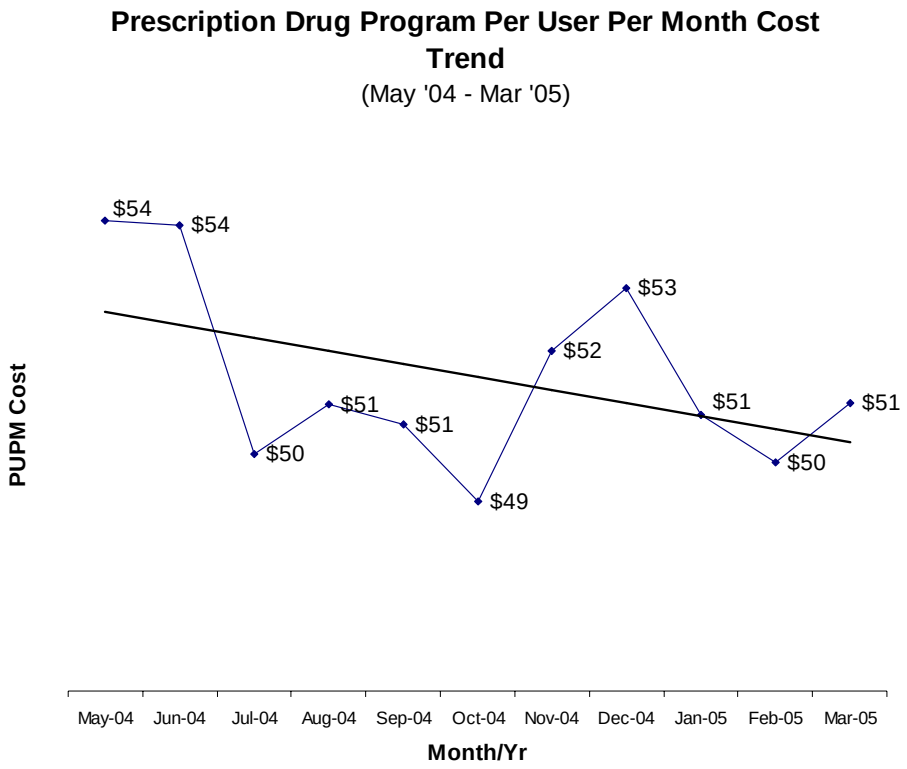
Is the Preferred Drug List reducing prescription drug costs?



Analysis

- Average program costs per user for prescriptions on the Preferred Drug List (PDL) have declined since implementation of the Therapeutic Interchange Program in May 2004.

Action

- Continue to educate providers and consumers about the efficacy and cost-effectiveness of the drugs on the PDL to promote preferred drug use.
- Target variation from PDL compliance and develop educational programs and interventions to improve provider compliance.
- Continue to expand the PDL and encourage the use of lower cost preferred drugs.
- Set a target by January 2006.

Data notes: Sources: UMP, DSHS, L&I. Cost basis is Maximum Allowable Cost (MAC). UMP allows 90-day prescriptions and this variance is accounted for by dividing MAC by number of 30-day episodes. Drug classes included are ACE Inhibitors, Beta-Blockers, Calcium Channel Blockers, Estrogens, Hypoglycemics, Statins, Long-Acting Opioids, NSAIDs/COX-II, PPIs, Skeletal Muscle Relaxants, Triptans, Urinary Incontinence.

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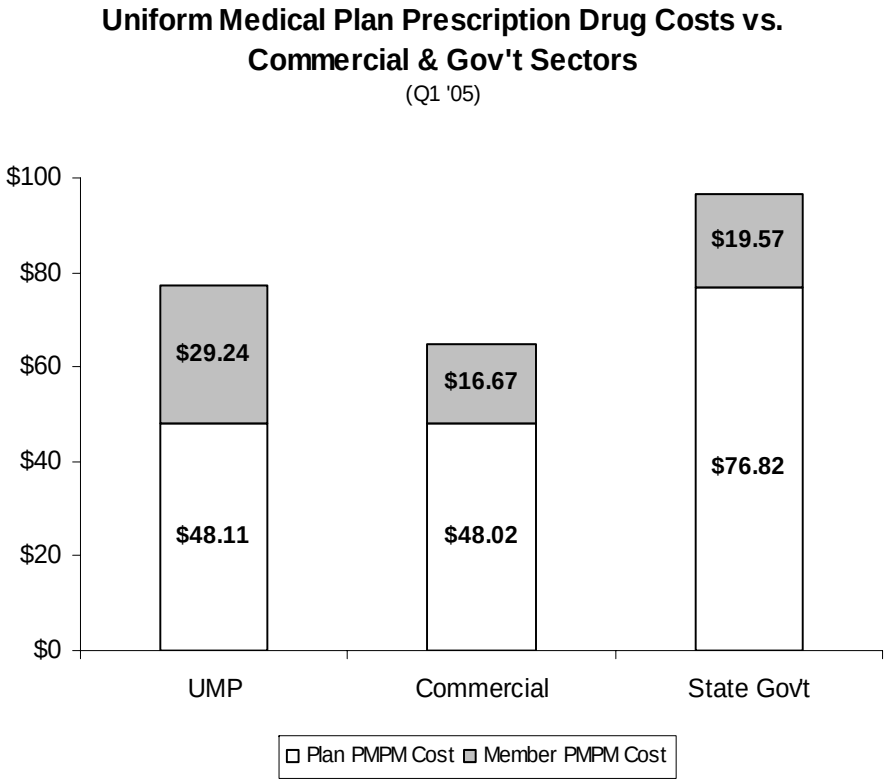
Does cost-sharing reduce total cost on prescriptions?



Analysis

- Per member per month (PMPM) prescription costs are lower at HCA than other government sectors.
- Member cost share is higher at HCA (37.8%).
- UMP has a higher percentage of Medicare retirees than commercial plans.
- Use of Preferred Drug List has slowed rate of growth of drug costs.

Action

- Continue to partner with the Prescription Drug Program and provide clinical support for the Pharmacy & Therapeutics Committee.
- Continue to implement initiatives to be more in line with the benchmark of the commercial prescription drug costs.

Data notes: Source: 2005 ExpresScripts Annual Review & Strategic Planning Session document. Total PMPM Cost is derived mathematically from Plan PMPM Cost and Member Cost Share.

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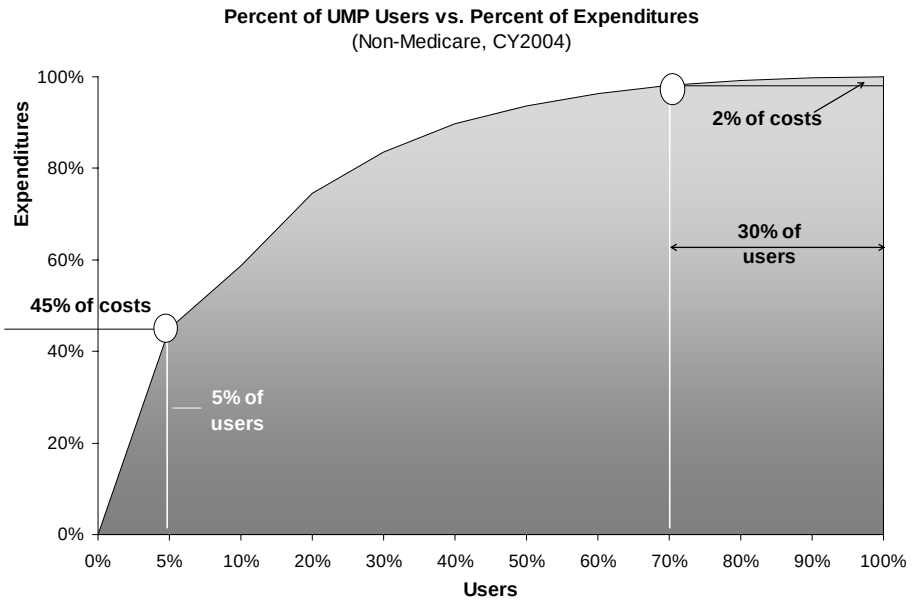
Health Care Authority & DSHS Goal 2: Improve Quality and Efficiency

Will case management improve quality and efficiency?

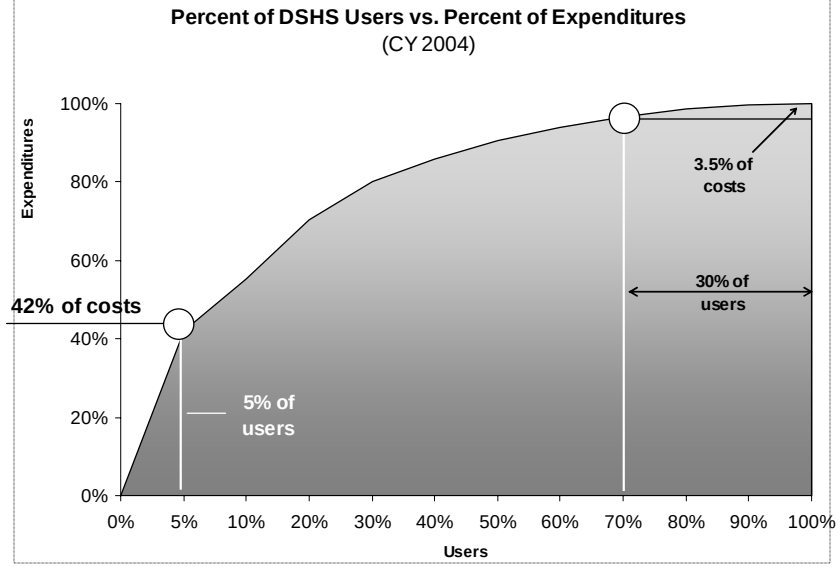


Action

- Use predictive modeling methods to identify enrollees who account for highest expenditures
- Develop high-cost care management strategies

Analysis

- The top 5% of UMP enrollees are responsible for 45% of expenditures ($153M).
- The top 5% of Medicaid enrollees are responsible for 42% of expenditures ($1.2B).



Data notes: Sources: 2004 Uniform Medical Plan claims. 2004 DSHS Medicaid Management Information System.

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Health Care Authority & DSHS Goal 2: Improve Quality and Efficiency

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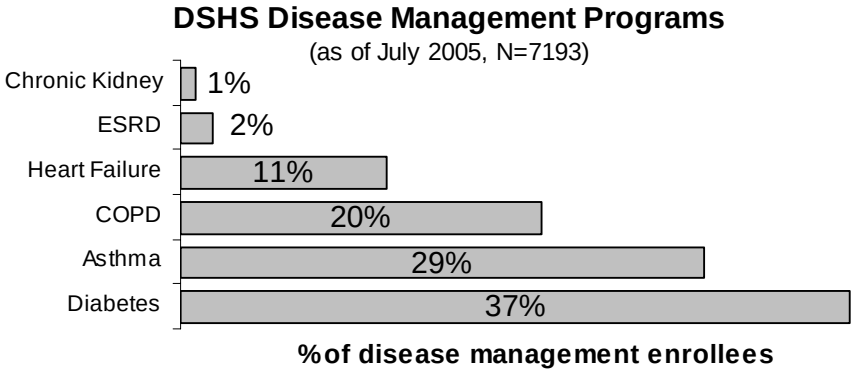

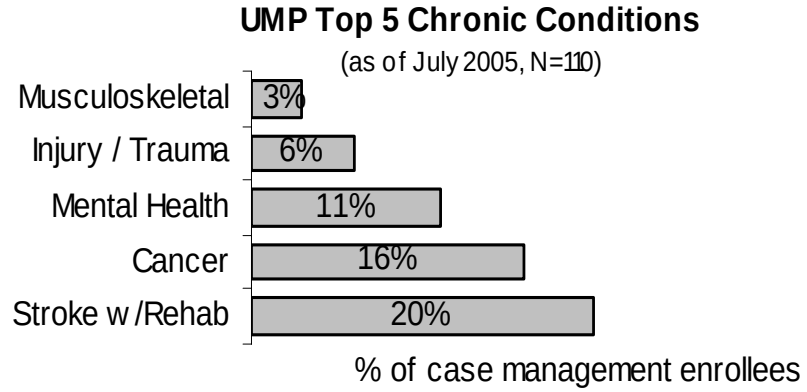

Analysis

- Case management could have 13% impact on health care spending*.
- DSHS has not realized return on investment after 3 years of disease management.

Action

- Improve identification of enrollees who could benefit from case management services.
- Decrease days in hospitals and skilled nursing facilities.
- Introduce innovative programs that increase quality of care and health outcomes.
- Provide incentives for Uniform Medical Plan members to complete Health Risk Assessment.

Data notes: Source: Uniform Medical Plan claims, DSHS Disease Management program. DSHS Asthma figures contain children enrolled in Healthy Options and TANF clients. Children will not be enrolled after 8/1/05. * 2002 Mercer Report to WA Business Roundtable.

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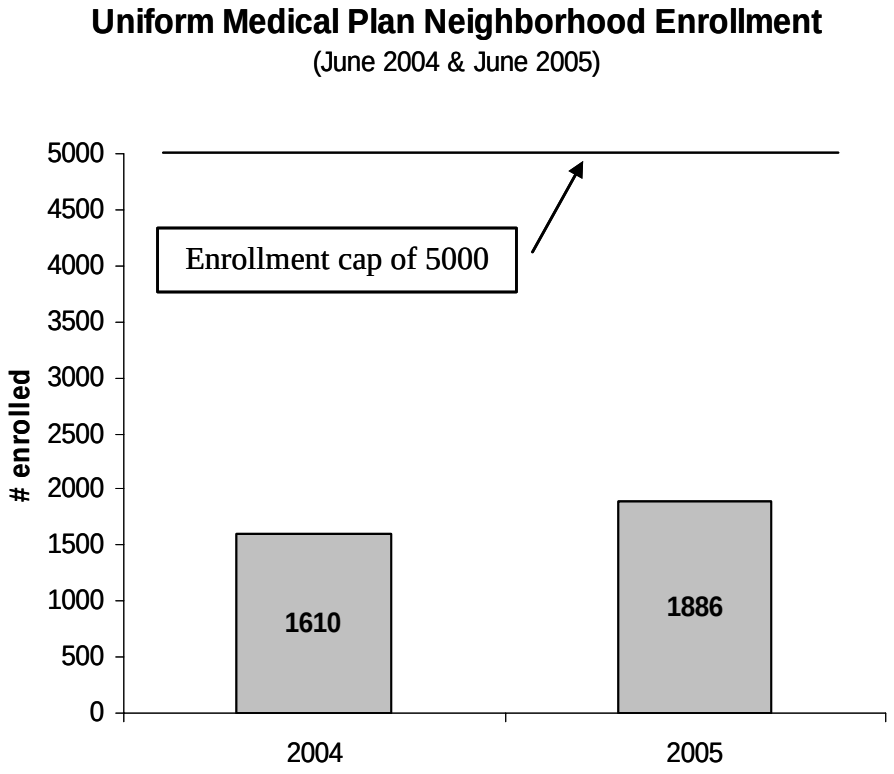
Goal 2: Improve Quality and Efficiency

Are creative benefit designs attracting membership?



Analysis

- Enrollment in UMP Neighborhood is increasing.
- Numerous opportunities to increase enrollment.

Action

- Market UMP Neighborhood as an innovative health plan option designed to identify 'care systems" that deliver cost-effective care and offer lower costs to enrollees who use them.
- Benefit design changes in 2006 are expected to attract enrollment (removing med/surg deductible).
- Recruit and continue to attract high quality providers.
- Follow up on Pay for Performance programs for providers.

Data notes: Source: Uniform Medical Plan (UMP). 2004 Pilot includes subscribers and dependents in King, Pierce and Snohomish counties only.

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DSHS/HCA/L&I

Goal 2: Improve Quality and Efficiency

What mechanisms will the State use to improve quality and efficiency?

Using Health Plan and Provider Information to Evaluate and Improve Quality

•Promote the transparency/clarity of health plan and provider information and performance.

•Work with Puget Sound Health Alliance (PSHA) to develop data warehouse/decision-support system capabilities as tools to evaluate provider quality and cost.

•Develop a plan to support and encourage the success of PSHA and other collaborative efforts.

Using Medical Evidence to Guide Coverage decisions

•Implement evidenced based assessment of new technologies and coverage decisions across agencies.

•Use evidence based assessments to inform state reimbursement priorities.

Data notes: From the Governor's Work Groups on Health Care Quality and Cost Work Plan. Targets will be set by next GMAP.

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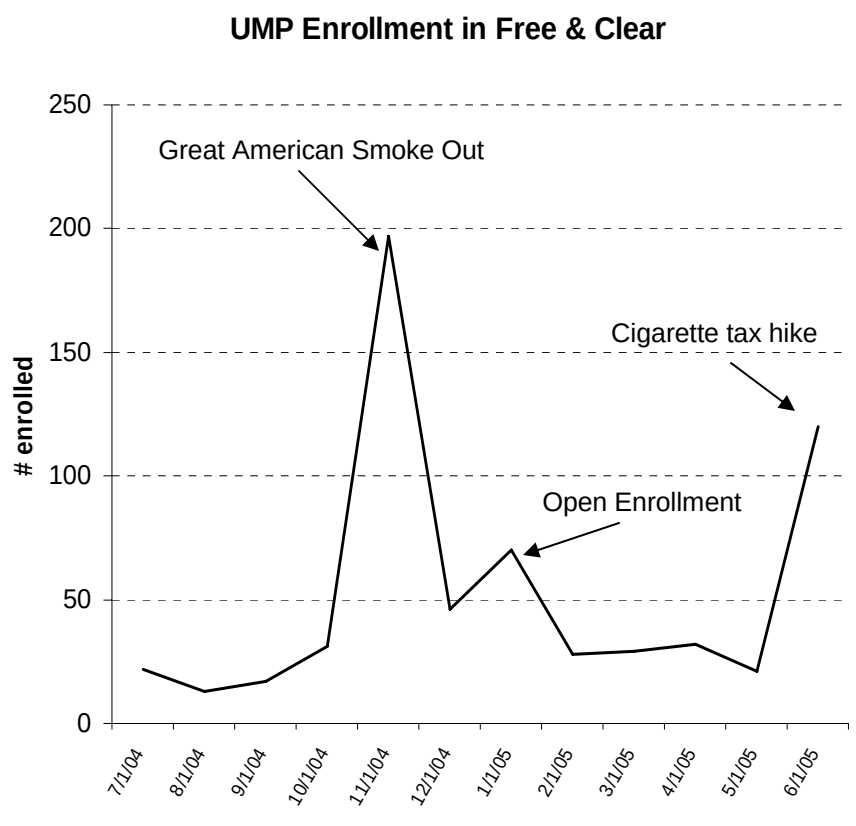
Goal 3: Improve the health of WA residents

How can we improve the health of our enrollees?



Analysis

- State smoking rates have significantly decreased over the last 15 years: 2004: 19.5% 2003: 21.5% 1990 28.6%
- UMP population smoking rate is 12-14%
- Enrollment in Free & Clear represents less than 1% of UMP smokers
- Of participants registered from 5/04 -5/05, the one month quit rate was 17%

Action

- Pursue prime marketing opportunities for enrollment (e.g., open enrollment, annual smoke out, tax hikes)
- Remove barriers to access.
- Increase quality of reporting from Free & Clear program
- Provide cash incentives for success

Data notes: Free and Clear annual report. UMP claims data.

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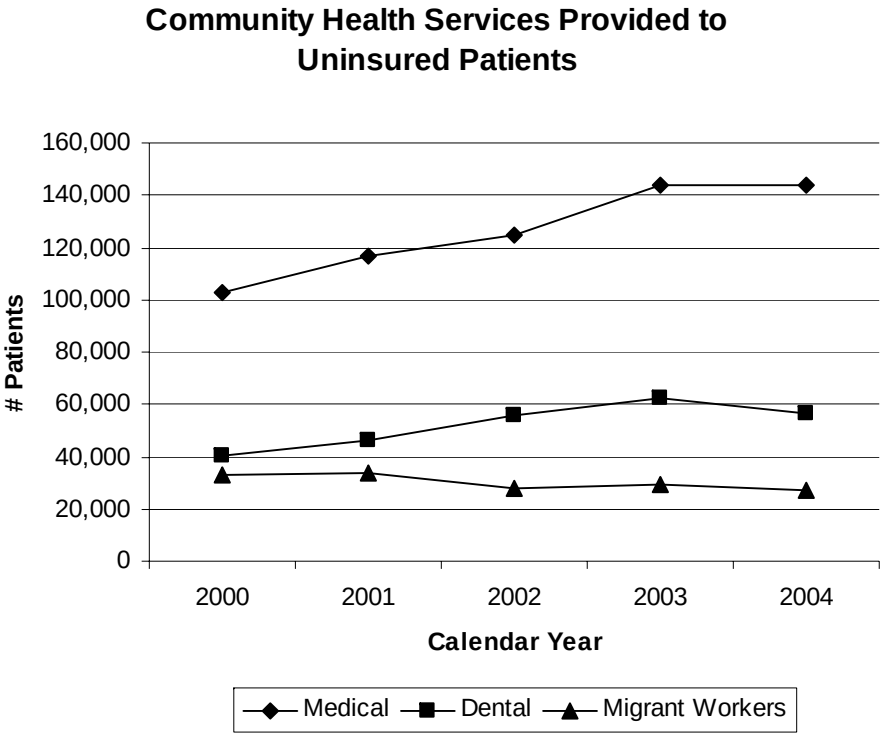
Health Care Authority Goal 4: Increase the Number of Insured Residents

Are we providing affordable access to under- and uninsured?



Analysis

- Increasing numbers of uninsured patients are being served by community clinics throughout the State.
- Slight trend from uninsured status to Medicaid.
- Funding cut by nearly 25% ($5 million) for 2005-2007 biennium. Service and staffing levels will be impacted throughout State.

Action

- Continue to identify and address real or potential barriers to access.
- Conduct technical site visits to monitor contract compliance and provide assistance.
- Increase the number of contractors in underserved areas.
- Build partnerships with communities including tribes and actively engage them.
- Legislative proposals (funding, collaborations).

Data notes: Source: CHS 2004 Annual Report. This is only one source of dollars that are provided to community clinics/ Federal Qualified Health Clinics (FQHC) from state and /or federal dollars.

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